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Testimony of Francys Crevier, Executive Director of the National Council of Urban Indian Health, before the U.S. Commission on Civil Rights Virtual Public Briefing:  
**Assessing COVID-19 and the Broken Promises to Native Americans**

Good morning and thank you for holding this important briefing to follow-up on the 2018 *Broken Promises* report and assess whether the federal government is meeting its obligations to Native American people in this current crisis. My name is Francys Crevier, I am a member of the Algonquin First Nation with a background in Indian law and policy, and it has been my honor to serve as the Executive Director of the National Council of Urban Indian Health (NCUIH), which represents 41 Title V Urban Indian Organizations (UIOs) across the nation.

UIOs provide high-quality, culturally competent care to urban Indian populations, constituting more than 78% of all American Indians and Alaska Natives (AI/ANs). UIOs were formally recognized by Congress in 1976 under the Indian Health Care Improvement Act to fulfill the federal government's health care-related trust responsibility to Indians who live off the reservations. Each UIO is led by a Board of Directors that must be majority AI/AN. They are collectively represented by NCUIH, which is a 501(c)(3), member-based organization devoted to the development of quality, accessible, and culturally sensitive healthcare programs for AI/ANs living in urban communities. UIOs are a critical part of the Indian Health Service (IHS), which oversees a three-prong system for the provision of health care: IHS facilities, Tribal Programs, and UIOs. This is commonly referred to as the I/T/U system.

More specifically, UIOs provide culturally competent health care services and resources that are critical to addressing the health care challenges that many AI/ANs face. However, as the *Broken Promises* report makes clear, UIOs have historically struggled with chronic underfunding, which severely limits the services that can be provided and the AI/AN patients they are able to serve. This constant underfunding from the federal government, in turn, impacts its fulfillment of the federal obligation to AI/AN people.

Through numerous bodies of law including treaties and legislation, the federal government has codified a federal trust responsibility to AI/AN people. Among the most sacred of the duties encompassed within the federal trust responsibility is the duty to provide for Indian health care. Congress has long recognized the federal government's obligation to provide health care for AI/AN people off of reservations. For instance, during the enactment of the 1987 Indian Health Care Improvement Act amendments, Congress declared: "The responsibility for the provision of health care, arising from



treaties and laws that recognize this responsibility as an exchange for the cession of millions of acres of Indian land does not end at the borders of an Indian reservation. Rather, government relocation policies which designated certain urban areas as relocation centers for Indians, have in many instances forced Indian people who did not [want] to leave their reservations to relocate in urban areas, and the responsibility for the provision of health care services follows them there.”<sup>1</sup>

COVID-19 is impacting Native American communities with respect to healthcare, housing, and infrastructure components. Data show that reoccurring health problems are more acute for AI/ANs living in urban areas and these health disparities have only been further exacerbated by COVID-19. Urban Indians have greater rates of mortality from chronic disease compared to all other populations, this includes a diabetes death rate 1.2 times greater, a chronic liver disease death rate 2.1 times greater, and a tuberculosis death rate 3 times greater. Infant mortality is also higher among urban Indians than the non-Indian urban population, with 7.8 deaths per 1,000 live births compared with 6.4 deaths per 1,000 live births. Urban Indians also have greater suicide rates, at 13 per 100,000 compared with 9.2 per 100,000. Urban Indians are also less likely to receive preventive care compared with the non-Indian urban population and less likely to have health insurance. Higher transmission rates of COVID-19 may be attributable to multigenerational home settings, which increases exposure to more vulnerable populations and makes social distancing and other safeguards more difficult.

The federal trust responsibility to provide health care has historically been underfunded, and has not been given consideration for inflation or population growth in urban Indian communities. Currently, UIOs receive less than 1% of the IHS budget through only one line item – the urban Indian healthcare line item, and the IHS budget is itself underfunded at less than 50% of need, creating serious budget constraints. A recent GAO report demonstrates that IHS is underfunded at around \$4,000 per patient (as compared to nearly \$11,000 per patient at the VHA), and urban Indian health patients receive even less funding per patient because not only do they receive less than 1% of the total IHS budget, but they do not have access to the other line items such as the facilities funding budget.

More specific to COVID-19, NCUIH is appreciative of the Congressional response to address Indian Country’s needs. We acknowledge that the Indian Health Service has received \$1.096 billion in supplemental funds to support relief and recovery efforts, including \$64 million in the Families First Coronavirus Response Act and \$1.032 billion in the CARES Act. Of this amount, \$515 million was allocated to federal, tribal, and urban

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<sup>1</sup> S. Rep. 100-508, Indian Health Care Amendments of 1987, Sept. 14, 1988, at 25.

Indian programs to assist with access to testing, telehealth services, and public health support efforts. We would like to emphasize how essential access to testing is for our communities and we are appreciative of the \$69 million IHS allocated to support testing efforts, \$64 million from the Families First Coronavirus Response Act was used to purchase rapid point-of-care tests for IHS and tribal health facilities (\$61 million) and \$3 million to Urban Indian Organizations. To date, IHS has received 250 rapid testing machines, distributing them to select locations to promote access for remote and rural populations. Another important funding component includes the expansion of telehealth services as many AI/ANs lack access to broadband services--IHS allocated \$95 million to help ensure AI/AN people can access health care from home without putting themselves or others at risk. However, these funds have yet to reach UIOs. Even in urban areas, many UIOs do not have the capacity to ramp up telehealth and their patients lack the resources necessary to conduct appointments virtually. Other public health support efforts that have been beneficial include providing information on available hospital beds, intensive care unit beds, tests, ventilators, and personal protective equipment (PPE).

Importantly, NCUIH would also like to advocate for urban Indians to be included in language for ALL new health programs - When urban Indians are not explicitly mentioned in programmatic language, they are implicitly excluded from participating in such programs. UIOs are not considered tribal organizations, which is a common misconception. Therefore, UIOs must be explicitly included to receive parity with the remainder of the I/T/U system. All too often, urban Indian organizations are excluded from laws intended to benefit American Indians and improve their quality of health, because of a lack of the understanding of the history of urban Indian communities and complexity of the Indian health care delivery system.

Thank you again for holding this virtual briefing today. I appreciate the opportunity to provide testimony to discuss the consequences of disparities in telecommunications, housing conditions, and access to infrastructure; the data that identifies how health disparities have been exacerbated during the pandemic; and what more is needed in the responses of the Administration and Congress to meet the needs of the Native American community in responding to and coping with the challenges posed by COVID-19. We look forward to working together to address these issues and arrive at updated findings and recommendations for the *Broken Promises* report.